DOCUMENT RESUME

ED 172 116 CG 013 559

AUTHOR Mezoff, Robert M.
TITLE Sensitivity Training...Is It Really Therapy In Disguise?
PUB DATE [75]
NOTE 16p.; Document prepared by ODT Associates, Amherst, MA

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Behavioral Science Research; Behavior Patterns; *Counselor Attitudes; *Group Counseling; Models; *Professional Personnel; *Psychological Characteristics; *Psychotherapy; *Sensitivity Training; T Groups; Therapists

ABSTRACT

Classification of current group therapies by three main criteria provides a useful conceptualization of why therapy is sometimes difficult to distinguish from the NTL-model T-group. The appropriateness of sensitivity training based on the criteria of "client normality" identifies several perspectives, including the futility and inadvisability of attempting to distinguish between "sick" and normal persons. It is suggested that the distinctions made between therapy and sensitivity training are, in part, a function of the personal motives of the professionals in both these areas. (Author)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED172116

ODT ASSOCIATES

Consultation and Training

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Robert M. Mezoff

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

Sensitivity training ...

is it really therapy in disguise?

by

Robert M. Mezoff

principal

ODT Associates

CG013559

174 Village Park Amherst, Massachusetts U.S.A. 01002 (413) 549-3828

Sensitivity Training...Is It Really Therapy in Disguise?

Abstract

This paper will classify current group therapies by three main criteria. The result provides a useful conceptualization of why therapy is sometimes difficult to distinguish from the NTL-model T-group. The appropriateness of sensitivity training based on the criteria of "client normality" is explored. Several perspectives demonstrate the futility (and inadvisability) of attempting to distinguish between "sick" and normal persons. Could it be that the distinctions that are made between therapy and sensitivity training are, in part, a function of the personal motives of the professionals in both these areas?

Among the critics and supporters of sensitivity training the issue of whether it constitutes therapy is a hotly debated topic. None of the critics and very few of the supporters of T-groups have established exactly what is meant by "therapy." The first part of this paper will review the range of "therapy" today and frame the issue in a larger context.

Most of the supporters of sensitivity training[1] who contend there is a difference between T-groups and therapy compare the NTL-model T-group and the psychoanalytical model of therapy. The major distinctions are summarized in FIGURE 1.

[1]Argyris, 1967; Blumberg, 1971; Bradford, 1964; Golembiewski, 1970.

FIGURE 1

Major Distinctions Between Psychoanalytic Group Therapy and the NTL-model T-Group.

Distinction	Therapy	T-Group
1. Time Focus	there & then (historical)	Here & Now (present)
2. Deals with	unconscious	conscious
3. Participants	considered "sick"	assumed normal
4. Responsibility	rests with therapist	assumed by group

Each of these major distinctions shall be investigated with respect to other modes (or models) of therapy. It should be noted that the psychoanalytical model of therapy is probably more different from T-groups than any other therapy model. It is certainly the oldest, most common model of therapy in use today...but to say that this is what "therapy" is, would be to ignore the vast variety of models in practice. This paper will now consider distinctions 1, 2, and 4 in FIGURE 1. Distinction 3, client normality or sickness, will be discussed later and such a distinction will be shown to be a spurious one, or at the very least useless and intractable.

This author has taken the liberty of reformulating the 2nd distinction (deals with unconscious v. conscious). This is useful because the distinction is appropriate to psychoanalytic therapy but less appropriate to some other therapy modes. Though the unconscious is not explored explicitly in T-groups, participants do learn about parts of themselves (through the process of receiving feedback) that they were not conscious of.

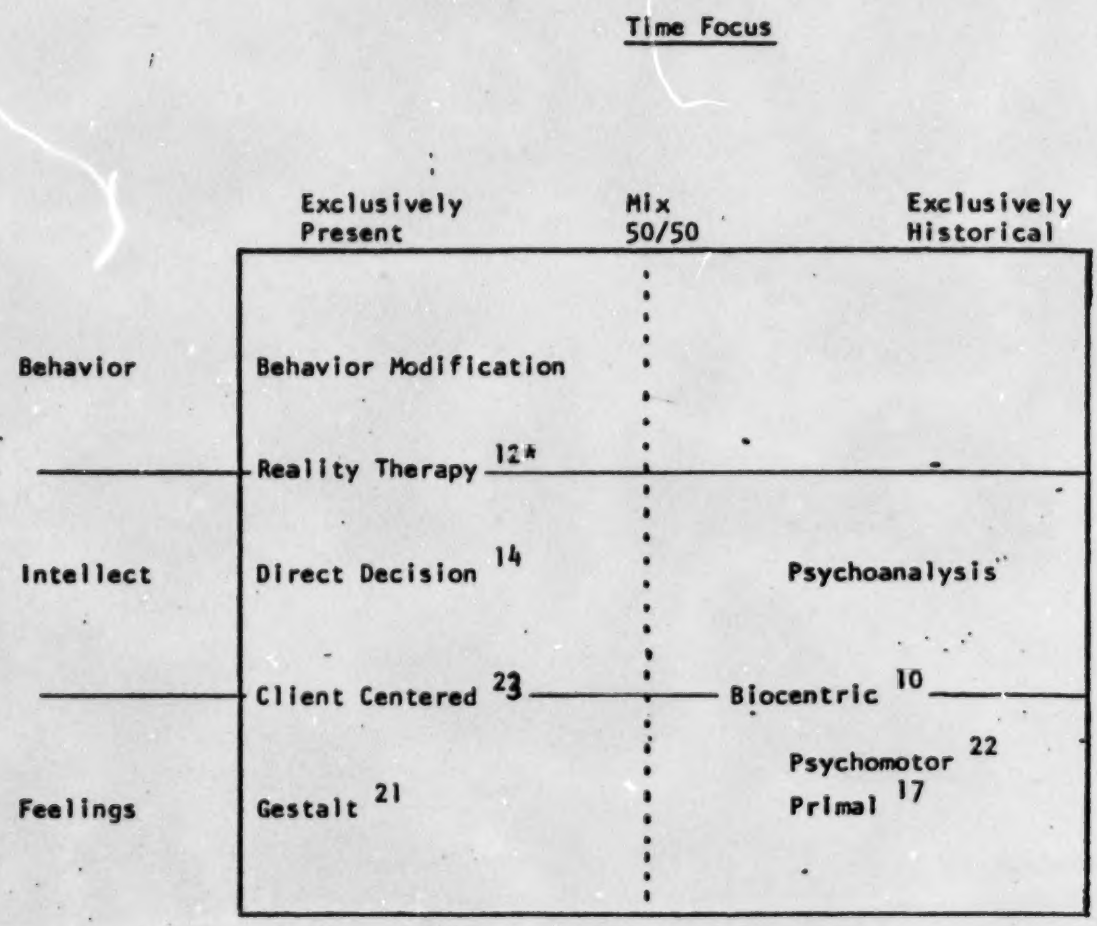
Therefore, this paper will consider the "aspect focus" of different therapies. The three major aspects to be considered are Behavior, Intellect,

and Feelings. This could be expanded to include Spiritual or Transpersonal Awareness, as newer therapy models also include these aspects (Assagioli, 1965; Tart, 1975; Weide, 1973).

Different therapies are focused on different levels. FIGURE 2 is one useful way to distinguish between the primary foci of some current therapies. The boundaries are not rigid nor are the models mutually exclusive.

FIGURE 2

Classification of Group Therapies by Time Focus and Aspect Focus.



* Numbers in FIGURE 2 are indexed to bibliography.

Aspect focus means the primary focus of a particular therapy technique. Behavior is what the person does, Intellect is what the person thinks and understands, and Feelings is what the person feels. Note that talking about feelings would be Intellect, whereas expressing feelings would be Feelings. In FIGURE 2, those therapies that share equally two foci are placed on the border between them.

The three levels of aspect focus are integrally interrelated. Whenever an individual makes significant changes in his/her life, change is noted on all three levels. Change on any one level can effect the other two levels, but not necessarily so. For a change to be permanently incorporated into a person's life it must be accepted and integrated on all three levels.

Time focus can range from exclusively in the present (here and now Behavior, Intellect & Feelings) to exclusively historical (there & then Intellect and Feelings[2]).

Clearly, there is a wide range of perspectives among different therapies. The T-group supporters who address the therapy-training controversy almost always contrast T-groups with conventional group psychoanalysis. A wider view of therapies would reveal greater similarity between sensitivity training and non-psychoanalytical therapy approaches. In fact, "the differences within both the T-group field and the therapy group field may be greater than the differences between the two fields."[3]

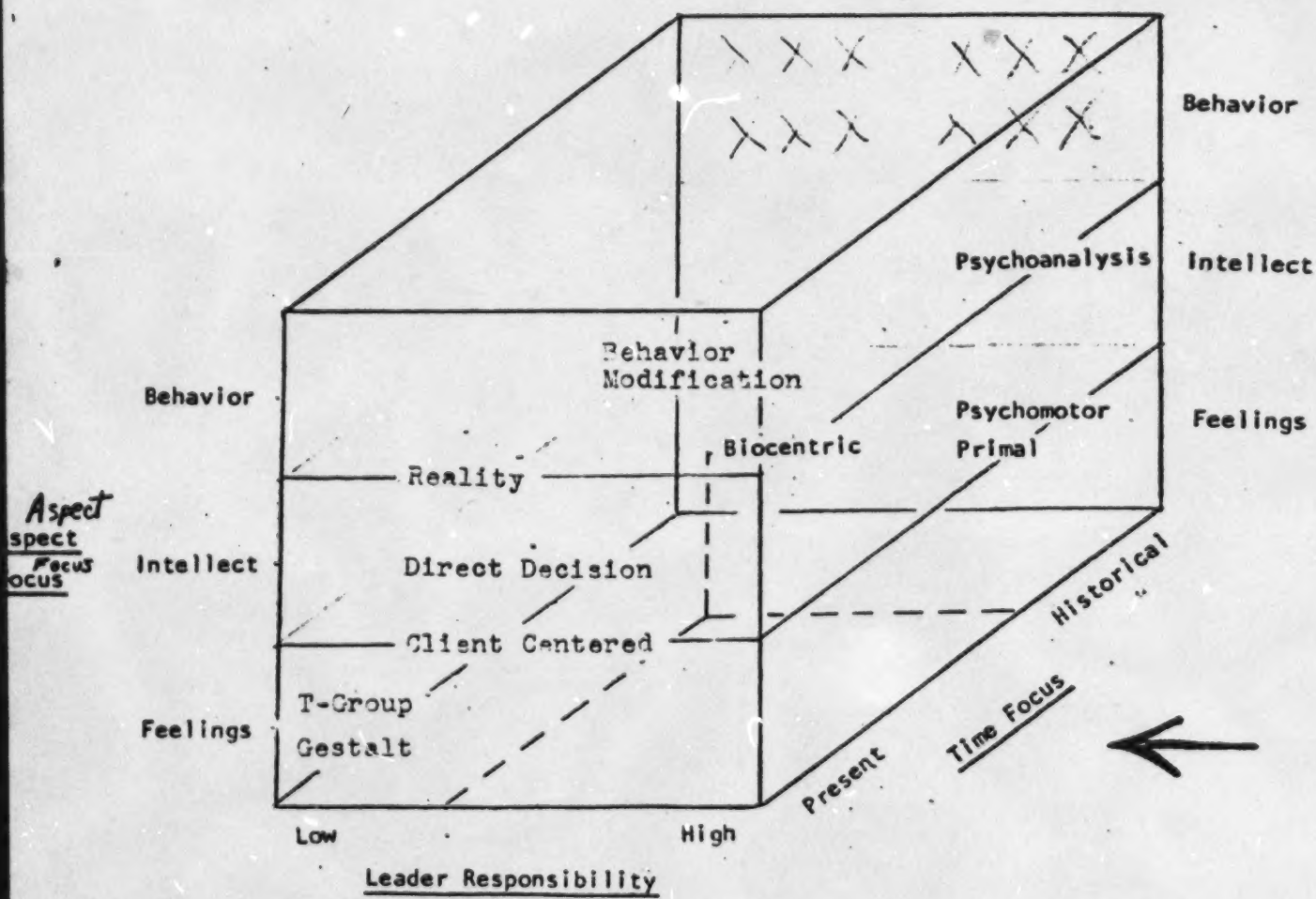
[2]Historical behavior is not considered because we would need a movie (or videotape) of past behavior to objectively capture it. All we have is the individual's cognitive perceptions (Intellect) and emotional perceptions (Feelings) of his/her past.

[3]Yalom, 1970, p. 362.

If we considered the previous matrix (Time focus X Aspect focus) and added a 3rd dimension of "Leader Responsibility for the client's growth,"[4] we will have a useful conceptual scheme for making distinctions between various therapies and T-groups (see FIGURE 3). In the T-group Leader Responsibility is extremely low and in conventional psychoanalysis Leader Responsibility is extremely high.

FIGURE 3

Classification of Group Therapies and NTL-model T-Group by Time Focus, Aspect Focus and Leader Responsibility. (As viewed from the arrow FIGURE 3 is identical with FIGURE 2).



[4] If one considers an alternate perspective of leader responsibility, say initiating structure, then the scheme becomes altered and T-groups and group psychoanalysis would share the trait of low structure provided by the leader.

FIGURE 3 is helpful in understanding how the distinctions between therapy and T-groups are subject to a broad range of interpretation. Two other factors also serve to cloud the issue:

1. It has become harder to distinguish between therapy and T-groups because the boundaries of the foci are not rigid.

2. The primary aspect focus may have a secondary (or tertiary) aspect focus. In fact, it usually will so that growth or change can become permanent for the individual (see page 4).

This paper is investigating only the variety among different "therapies." There is a wide variety among T-groups as well, and such diversity adds considerably to the difficulties in distinguishing between the two fields.

Observe how in FIGURE 3 T-groups are as distant from (and as different from) Psychoanalysis as they could possibly be. Also, how some other therapy models are much more similar to T-groups, especially Gestalt and Client-Centered therapy.

Normality

A major distinction made by T-group supporters is that T-groups function to increase the potential of the participant; whereas therapy is designed to remedy a deficiency or personal problem. Blumberg (1971) says that therapy can be "seen as a vehicle for overcoming serious characterological deficiencies or as a way of dealing with mental illness." Some helping professionals do not accept that there is such a thing as mental illness (Szaz, 1961). Others (Glasser, 1965; Greenwald, 1971) claim that by using such terms as "neurotic," "psychotic," etc. we block people from changing and improving their lives. The notion is that by acknowledging

psychiatric terms we let people use their "condition" as an excuse not to change ("I can't help it, I'm neurotic.")

Normality will be explored in two contexts: (1) how people are seen by others, and (2) how people feel about themselves. Research has shown that there exists a relationship between acceptance of self and acceptance of others. A person with high self-esteem is more likely to perceive another as normal (acceptable); whereas a low self-esteem individual is more likely to perceive another as "sick" (unacceptable). So the person who is doing the perceiving may be a factor in whether an individual is seen as normal or "sick".

It seems that most investigators assume an unidimensional scale of normality which ranges from "sick" or subnormal to normal to super-normal (Swartley, 1973; Boone, 1975). It is not clear whether a statistical definition of normal is being used or some other criteria is being applied. The criteria sometimes referred to involves the client's ability to function in his/her major relationships[5] (work, family, etc.). If functioning is the sole criteria of normality it excludes the vast amount of hidden personal thoughts and feelings that may not manifest itself in observable behavior. It seems simplistic to say that being normal or "sick" is contingent only upon observable behavior and not how the person feels or thinks.

For simplification purposes let us dichotorize people as appearing either normal or "sick". There is also the factor of whether the person feels or thinks themselves to be normal or "sick". There then exist four different outcomes as to how people might express their conditions. These are: (1) congruent normal, a person who feels normal and acts normal;

[5]Bradford, 1964, p. 30.

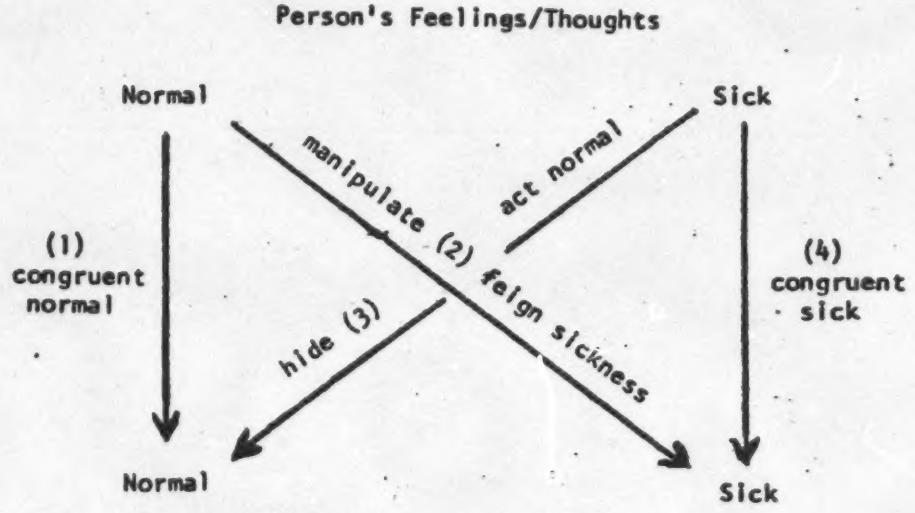
(2) a manipulator, a person who feels normal and feigns sickness;

(3) a person who hides that he/she feels "sick" and acts normal, and

(4) a congruent "sick", a person who feels "sick" and acts it.

FIGURE 4

Simplistic Matrix Depicting Four Possible Expressions of Normality/"Sickness"



The above scheme reveals great complications surrounding the distinctions between normality and sickness, and only our gross simplification (dichotomizing people as normal or "sick") has allowed us to get to this far.

How a person feels about himself probably correlates to how he comes across to others. Transactional Analysis (Harris, 1969) says that for an adult the difference between feeling normal (O.K.) and "sick" (not O.K.) is a conscious voluntary decision. Given this is true, then that conscious decision is a large factor in whether a person would appear as normal to others.

Overall, normality is a very ambiguous term. It is not a useful way to distinguish between the appropriateness of training or therapy. Argyris talks of normality on a scale from an "open" to a "closed" system (individual). He subscribes to the medical model wherein "therapy" means "to

cure", to restore to a healthy condition. By his own definition of therapy, Argyris limits therapy to being survival-oriented (psychoanalysis, behavior modification, reality therapy). Certainly most therapies have this orientation, but it must be acknowledged that some do not (primal therapy, gestalt therapy, psychomotor therapy).

The difficulty of using normality as a distinction for choosing between training and therapy is not meant to suggest that the choice between the two processes is inconsequential. Certainly the prolonged relationship between therapist and client is an aspect that T-groups do not offer. Yet some psychotherapists (non-psychoanalytical) with private practices often run weekend "workshops" at growth centers[6] which offer their therapy techniques to clients who choose not to enter an ongoing therapy process.

The needs of an individual are a factor in his/her choosing a T-group or a therapy group. If an individual is simply curious, he/she may investigate the benefits (and costs) of either experience. However, if an individual feels he/she is in great need of change it would likely be that he/she would choose a therapy group.

A person in great need for change will be likely to have a high expectation of the outcome of the relationship. One should not enter a T-group of limited duration expecting to have a lasting relationship with the leader or members. Similarly, it would be inappropriate for a person to seek out a psychoanalytical therapist and expect to have one or two sessions with him/her. It is imperative that T-groups or therapy

[6]Esalen, Anthos, Quest, Center for the Whole Person.

(of whatever kind) be explicit in what they are offering, so the client can have an appropriate set of expectations for the experience. This is one reason why T-groups offer cautionary statements that say the T-group experience is not "therapy". "Therapy" has tended to connote the psychoanalytical model's expectations and this is to be stringently avoided.

Other Reasons for the Distinctions Between T-Groups and Therapy

This paper initially distinguished among different therapies and contrasted them to T-groups. Previous authors who supported a position that there were significant distinctions between training and therapy almost always contrasted T-groups to conventional group psychoanalysis. One suspects that the bias of those T-group supporters would make it likely that they would choose that particular contrast, since the distinctions there were so great.

There are advantages for both T-group leaders and psychotherapists to contend there is a significant difference between what they do. They are as follows:

1. T-group leaders usually are not credentialed or "qualified" to do therapy. If what they did amounted to therapy then they would be "guilty of practicing medicine without a license, or, at least, passing themselves off as healers..."[7] Therefore it is in the interest of T-group leaders to avoid any connection between sensitivity training and therapy.

[7]Blumberg, 1971, p. 16.

2. Psychotherapists have gone through a severe "initiation" process to be able to practice their skills. If sensitivity training amounted to therapy then their self-esteem would be threatened by T-group leaders who had not been initiated into the medical profession. It is in the interest of their self-esteem that sensitivity training and psychotherapy be distinguished as being as different as possible. Further, that psychotherapists are more highly skilled (and prestigeous) than T-group leaders. It is typical of "the professions (to) erect 'No Trespassing' signs between themselves and other professional groups, especially the newer ones."[8]

3. It is also in the interest of the T-group leaders to avoid threatening the psychotherapists. If T-group leaders profess that sensitivity training is very different from therapy then psychotherapists are less likely to object to T-group leaders.

The phenomena at work here is one which is evident in our society from the professions down to blue-collar labor. Each work group seeks to draw distinctions between what it does and what a different group does. It has always been true that a highly skilled (high initiation cost) group has resisted encroachment from any source. Witness the American Medical Association resistance to military medics performing the same functions as civilians that they were quite competent performing in the military. Even among blue-collar workers there are

[8]Lynn, K., The Professions in America, Boston: Beacon Press, 1963.

stringent demarcations between their job duties (especially in a Union shop). The work in both of the above cases is attached to status, and that status is to be defended at all costs.

Summary

Sensitivity Training and therapy both help people grow and change.[9] To make distinctions between the general models (i.e. group psychotherapy and the NTL-model T-Group) is useful only to compare those specific modes. However, such a comparison does not consider the wide range of foci either might take (This paper has not even considered the variety among T-groups). Also, any distinctions predicated on "normality of clients" seems impossible to apply. Lastly, the vested interests of sensitivity trainers and psychotherapists sheds light upon why such great efforts have been made by them to draw distinctions between their fields.

My advice to any person undertaking any therapy process, sensitivity training, or personal growth experience would be as follows. Be clear on exactly what it is you are looking for from the experience. Discuss your goals with the leaders and make sure that your expectations are appropriate to the process. There are a multitude of ways to grow, and a few or many paths may be right for a given individual. Choose wisely, and choose with your heart and intuition as well as your intellect.

[9]Golembiewski, 1970, p. 10.

Bibliography

1 Appley, D. and Winder, A., T-Groups and Therapy Groups in a Changing Society, San Francisco: Jossey-Bass, Inc., 1973.

2 Argyris, C., "Conditions for Competency Acquisitions and Therapy", Journal of Applied Behavioral Science, Vol. 4, No. 2, 1968.

3 Argyris, C. "On the Future of Laboratory Education", Journal of Applied Behavioral Science, Vol. 3, No. 2, 1967.

4 Assagioli, R., Psychosynthesis, New York: Hobbs, Dorman & Company, 1965.

5 Back, K., Beyond Words, New York: Russell Sage, 1972.

6 Banet, A., "Therapeutic Intervention and the Perception of Process" in 1974 Annual Handbook for Group Facilitators, edited by Pfeiffer & Jones, Iowa City: Iowa University Associates, 1974. pp.179-188.

7 Blumberg, A., Sensitivity Training: Processes, Problems, and Applications, Syracuse, New York: Syracuse University Press, 1971.

8 Boone, T., "Therapy or Personal Growth?" in 1975 Annual Handbook for Group Facilitators, edited by Pfeiffer & Jones, Iowa City: Iowa University Associates, 1975. pp.141-142.

9 Bradford, L. Gibb, J. and Benne, K., T-Group Theory and Laboratory Method, New York: John Wiley & Sons, Inc., 1964.

10 Branden, N., Breaking Free, Los Angeles: Nash Publishers, 1970.

11 Clark, J. "Some Troublesome Dichotomies in Human Relations Training", Human Relations Training News, Vol. 6, No. 1, 1962.

12 Glasser, W., Reality Therapy, New York: Harper & Row, 1965.

13 Golembiewski, R. and Blumberg, A., Sensitivity Training and the Laboratory Approach, Itasca, Ill: F.E. Peacock Publishers, 1970.

14 Greenwald, H., "The Integration of Behavioral, Existential, and Psychoanalytic Therapy into Direct Decision Therapy", Journal of Contemporary Psychotherapy, Winter, 1971. Vol 4 (1) pp.37-43.

15 Harris, T., I'm O.K....You're O.K., New York: Harper & Row, 1969.

16 House, R. "T-Group Education and Leadership Effectiveness: A Review of the Empiric Literature and a Critical Evaluation", Personnel Psychology, Vol. 20, No. 1, 1967.

17 Janov, A., The Primal Scream, New York: Putnam, 1970.

18 Jones, J., "Types of Growth Groups" in 1972 Annual Handbook for Group Facilitators, edited by Pfeiffer & Jones, Iowa City: Iowa University Associates, 1972. pp. 145-151.

19 Lippitt, G. and This, L. "Leaders for Laboratory Training", Training & Development Journal, March 1967.

20 Lynn, Kenneth, The Professions in America, Beacon Press, Boston, 1963.

21 Perls, F., Gestalt Therapy, New York: Julian Press, 1951.

22 Pesso, A., Movement in Psychotherapy, New York: NYU Press, 1969.

23 Rogers, C., Client-Centered Therapy.

24 Schein, E. Process Consultation, Reading, Mass Addison-Wesley Publishing Company, 1969.

25 Shutz, W., Joy, New York: Grove Press, Inc., 1967.

26 Shutz, W., Here Comes Everybody, New York: Harper & Row, 1971.

27 Shutz, W., Elements of Encounter, Big Sur, California: Joy Press, 1973.

28 Swartley, W., "Growth Centers" in 1973 Annual Handbook for Group Facilitators, edited by Pfeiffer & Jones, Iowa City, Iowa University Associates, 1973. pp. 267-276

29 Szaz, T., Myth of Mental Illness, New York: Harper & Row, 1961.

30 Tart, C., Transpersonal Psychologies, New York: Harper & Row, 1975.

31 Walton, R., Third Party Consultation, Reading, Mass.: Addison Wesley Publishing Co., 1969.

32 Weide, T., "Varieties of Transpersonal Therapy" in Journal of Transpersonal Psychology #1, Vol. 5, pp. 7-14, 1973.

33 Winn, A., "Training Groups and Therapy Groups," Human Relations Training News, Fall, 1963. pp 4-6.

34 Yalom, I., The Theory and Practice of Group Psychotherapy, New York: Basic Books, 1970.